RULEMAKING NOTICE FORM

Notice Number	**2015-67**	Rule Number	**He-W 506.02, 506.03(d) & (i), 506.05, and 506.06**

1. Agency Name & Address:	2. RSA Authority: **RSA 126-A:5, XIX; RSA 161:4-a, IX**
NH Dept. of Health & Human Services **Office of Medicaid Business and Policy** **129 Pleasant Street** **Concord, NH 03301**	3. Federal Authority: 4. Type of Action: Adoption Amendment **X** Repeal Readoption Readoption w/amendment **X**

5. Short Title: **Medicaid Managed Care**

6. (a) Summary of what the rule says and of any proposed amendments:

He-W 506 is the rule that implements SB 147 (Chapter 125 of the Laws of 2011), which requires the Department to contract with vendors to provide managed care services to the state's Medicaid population. He-W 506 contains the requirements of the New Hampshire Medicaid Care Management (MCM) program as they pertain to Medicaid recipients, including covered services, enrollment in managed care, selection of a managed care organization, and grievance and appeal rights.

This proposal is changing various sections and paragraphs of He-W 506 to require mandatory enrollment in Medicaid Managed Care for those populations which could previously opt out of the program. These changes are contingent upon the approval of a waiver request from the Centers for Medicare and Medicaid Services.

6. (b) Brief description of the groups affected:

This rule affects those Medicaid recipients who could previously opt out of mandatory enrollment in Medicaid Managed Care, as well as the two Managed Care Organizations that have contracted with the State to provide managed care services to the state's Medicaid population.

6. (c) Specific section or sections of state statute or federal statute or regulation which the rule is intended to implement:

Rule	**Federal Reg./RSA**
He-W 506.02	RSA 126-A:5, XIX; §1932(a) of the SSA; 42 U.S.C. 1396u-2
He-W 506.03(d) & (i)[deleted]	§1932(a) of the SSA; 42 CFR 438.2; 42 U.S.C. 1396u-2
He-W 506.05	§1932(a)(4) of the SSA; §1915(b)1 of the SSA; §1915(b)(4) of the SSA; 42 CFR 438.56 and .226
He-W 506.06	§1932(a)(4) of the SSA; 42 CFR 438.52

7. Contact person for copies and questions including requests to accommodate persons with disabilities:

Name:	**Michael Holt**	Title:	**Rules Coordinator**
Address:	**Dept. of Health and Human Services** **Administrative Rules Unit** **129 Pleasant St.** **Concord, NH 03301**	Phone #: Fax#: E-mail:	**271-9234** **271-5590** **michael.holt@dhhs.state.nh.us**

TTY/TDD Access: Relay NH 1-800-735-2964 or dial 711 (in NH)

The proposed rules may be viewed and downloaded at:
http://www.dhhs.nh.gov/oos/aru/comment.htm

8. Deadline for submission of materials in writing or, if practicable for the agency, in the electronic format specified: **Wednesday, May 27, 2015**

☒Fax ☒E-mail ☐Other format (specify):

9. Public hearing scheduled for:

Date and Time: **Tuesday, May 19, 2015 at 10:30 AM**

Place: **DHHS Brown Bldg., Auditorium, 129 Pleasant St., Concord, NH**

10. Fiscal Impact Statement (Prepared by Legislative Budget Assistant)

FIS # **15:068**, dated **04/17/15**

1. **Comparison of the costs of the proposed rule(s) to the existing rule(s):**

When compared to the existing rules, the proposed rules may reduce state general fund and state restricted fund (Federal) expenditures by a total of $38,000,000 in FY 2016, and $46,400,000 in FY 2017, and may increase revenue to independently owned businesses by $61,800,000 in FY 2016, and $61,400,000 in FY 2017.

2. **Cite the Federal mandate. Identify the impact of state funds:**

No federal mandate, no impact on state funds.

3. **Cost and benefits of the proposed rule(s):**

A. **To State general or State special funds:**

The Department estimates the proposed rules will result in approximately 12,5000 Medicaid recipients being transitioned from a fee for service benefit paid directly by the Department to Medicaid providers to a managed care benefit with payments made by the Department to a managed care organization based on a per-member per-month (PMPM) fee schedule. Payments under both fee for service and managed care are funded 50% with federal funds and 50% with State general funds. The PMPM payments are projected to be lower than fee for service payments by a total of $38,000,000 in FY 2016 and $46,000,000 in FY 2017. Fifty percent of the projected savings will be to the state general fund in the amount of $19,000,000 in FY 2016 and $23,000,000 in FY 2017.

B. To State citizens and political subdivisions:

None.

C. To Independently owned businesses:

Medicaid Managed Care Organizations (MCOs) will increase enrollments by approximately 12,500 Medicaid recipients resulting in approximately $61,800,000 of additional revenues in FY 2016 and $61,400,000 in FY 2017. The additional revenue is funded 50% by the State and 50% with federal Medicaid funds.

11. Statement Relative to Part I, Article 28-a of the N.H. Constitution:

The proposed rules modify an existing program or responsibility, but do not mandate any fees, duties or expenditures on the political subdivisions of the state, and therefore do not violate Part I, Article 28-a of the N.H. Constitution.

CHAPTER He-W 500 MEDICAL ASSISTANCE

PART He-W 506 MEDICAID CARE MANAGEMENT (MCM)

Readopt with amendment He-W 506.02, effective 9/13/13 (Document #10410), to read as follows:

He-W 506.02 Scope. This part shall apply to all medicaid recipients insofar as they are required to enroll in managed care ~~or they voluntarily enroll in managed care~~. Those recipients who are not enrolled in managed care shall receive medicaid services on a fee-for-service basis in accordance with applicable rules in He-W 500.

Amend He-W 506.03, effective 9/13/13 (Document #10410), as amended effective 7/1/14 (Document #10631), by amending paragraph (d) and by deleting paragraph (i) and renumbering subsequent paragraphs, so that He-W 506.03(d) and (i) are cited and read as follows:

He-W 506.03 Definitions.

(d) "Enrollee" means a recipient who is enrolled in managed care and who has not yet selected an MCO. ~~This term includes the following:~~

~~(1) "Mandatory enrollee" means a recipient who is required to enroll, and has been enrolled, in managed care; and~~

~~(2) "Voluntary enrollee" means a recipient who is exempt from mandatory enrollment, who has chosen to enroll in managed care by not affirmatively opting out of managed care.~~

~~(i) "Mandatory enrollment" means the process whereby a recipient is enrolled in managed care, unless otherwise exempt or excluded.~~

Readopt with amendment He-W 506.05, effective 7/1/14 (Document #10631), to read as follows:

He-W 506.05 Enrollment in Managed Care.

(a) Enrollment in managed care shall be mandatory for all individuals who are eligible for medicaid through the NHHPP.

(b) All other medicaid recipients shall be enrolled in managed care unless~~:~~

~~(1) The recipient is federally exempt from mandatory enrollment pursuant to 42 USC §1396u-2(a)(2), as described in (c) below, and affirmatively opts out of managed care; or~~

~~(2) T~~the recipient is excluded from managed care as described in (c~~d~~) below.

~~(c) Recipients in the following aid categories shall be exempt from mandatory enrollment in managed care:~~

~~(1) Children under the age of 19 years who are eligible for Supplemental Security Income (SSI) under Title XVI of the Social Security Act;~~

~~(2) Children under the age of 19 years who are eligible for home care for children with severe disabilities (HC-CSD) pursuant to §1902(e)(3) of the Social Security Act and He-W 508;~~

~~(3) Children under the age of 19 years who are in foster care or other out-of-the-home placement;~~

~~(4) Children under the age of 19 years who are receiving foster care or adoption assistance under part E of subchapter IV of the Social Security Act;~~

~~(5) Children with special health care needs under the age of 19 years who are receiving services through a family-centered, community-based, coordinated care system that receives grant funds under section 501(a)(1)(D) of Title V of the Social Security Act; and~~

~~(6) Recipients who are Medicare dually eligible beneficiaries.~~

(c~~d~~) The following individuals shall not be allowed to enroll in managed care:

(1) Recipients receiving benefits from the U.S. Department of Veterans Affairs;

(2) Recipients receiving in and out medically needy assistance in accordance with 42 CFR 435.301 and He-W 678.01; and

(3) Individuals who have qualified medicare beneficiary/specified low-income medicare beneficiary (QMB/SLMB) benefits only, and are not eligible for medicaid service coverage.

(d~~e~~) Any recipient not enrolled in managed care shall receive medicaid services on a fee-for-service basis.

~~(f) Those recipients described in (c) above shall be allowed to disenroll from managed care at any time, with or without cause.~~

~~(g) An enrollee may disenroll from managed care if he or she has moved out of state~~.

Readopt with amendment He-W 506.06, effective 9/13/13 (Document #10410), to read as follows:

He-W 506.06 Selection of a Managed Care Organization.

(a) The department shall send a notice of managed care enrollment and MCO selection to all recipients not excluded from managed care per He-W 506.05(c).

(b) Recipients shall have 60 days from the date of the notice in (a) above select an MCO~~to~~ by responding to the department, via writing, telephone, or by utilizing the on-line NH Electronic Application System (NH EASY)~~, as follows:~~

~~(1) Those recipients who are required to enroll in managed care shall select an MCO; and~~

~~(2) Those recipients exempt from mandatory enrollment per He-W 506.05(a)(1) shall either:~~

~~a. Select an MCO, thereby enrolling in managed care; or~~

~~b. Affirmatively indicate to the department their choice to not enroll in managed care.~~

(c) If a recipient fails to select a~~A~~n MCO as required by (b) above, an MCO shall be auto-assigned to the recipient.~~:~~

~~(1) Those recipients in (b)(1) above who do not select an MCO; and~~

~~(2) Those recipients in (b)(2) above who do not meet either of the requirements in (b)(2) above.~~

(d) Auto-assignments shall be based on the following criteria:

(1) MCO participation of a primary care provider with whom the enrollee has a pre-existing relationship as demonstrated by past claims history;

(2) MCO participation of a specialty care provider with whom the enrollee has a pre-existing relationship as demonstrated by past claims history;

(3) MCO selection by a household family member of the enrollee;

(4) MCO previously selected prior to a loss of medicaid eligibility; or

(5) If no assignment can be made utilizing (1)-(4) above, assignment shall be based on an algorithm, which has been contractually agreed to by the department and the MCO, that ensures equitable enrollment of enrollees across all MCOs.

(e) A member may request to change his or her MCO selection without cause, by making a written or oral request to the department at any of the following times:

(1) During the 90 days following the date of the member's initial selection of or the auto-assignment to the MCO, or the date the department sends the member confirmation of the member's selection or auto-assignment, whichever is later;

(2) At any time for members who are auto-assigned to the MCO and who have an established relationship with a primary care provider that is only in the network of a non-assigned MCO;

~~(3) At any time for members who were voluntary enrollees;~~

(3~~4~~) During annual open enrollment periods ~~every 12 months~~; and

(4~~5~~) For 60 ~~calendar~~ days following an automatic re-enrollment if the temporary loss of medicaid eligibility causes the member to miss the annual re-enrollment/disenrollment opportunity. This provision shall apply to redeterminations only and shall not apply when an individual is completing a new application for medicaid eligibility.

(f) A member may request to change his or her MCO selection with cause, by making a written or oral request to the department at any time for any of the following reasons:

(1) The member requires related services simultaneously that are not available in the MCO's network and bifurcation of the care creates unnecessary risk to the member as determined by the member's treating provider;

(2) The member wants to select the same managed care plan as a household family member;

(3) Poor quality of care;

(4) Lack of access to covered services;

(5) The member has experienced a violation of his or her member rights, as established in 42 CFR 438.100; or

(6) The MCO's network providers are not experienced in the member's unique healthcare needs.

(g) If a request made pursuant to (e) or (f) above does not include the selection of a different MCO, the department shall not act on the request unless there are only 2 MCOs.

(h) A member may request a department fair hearing of a denial of (e) or (f) above in accordance with He-C 200 without first exhausting the MCO appeal process.

(i) ~~For members who are mandatory enrollees, the~~A member shall be locked into the selected or auto-assigned MCO for a period of 12 months or until the next open enrollment period, whichever comes first, unless the member changes his or her MCO selection in accordance with (e)(1), (2), (5), or (f) above.

(j) A member may disenroll from an MCO ~~if~~ when the member has moved out of state and is no longer NH medicaid eligible.

(k) An MCO may request the department to disenroll a member who is threatening or abusive such that the health or safety of other members, MCO staff, or providers is jeopardized.

(l) The department shall approve a request for disenrollment in (k) above when no other option is available that would ensure the health and safety of other members, MCO staff, or providers.

(m) If the department approves an MCO request for involuntary disenrollment, the member may request a department fair hearing of the disenrollment in accordance with He-C 200 without first exhausting the MCO appeal process.

(n) Members appealing involuntary disenrollment may request a continuation of services pending appeal as outlined in 42 CFR 431.230.

APPENDIX B

RULE	STATE OR FEDERAL STATUTE THE RULE IMPLEMENTS
He-W 506.02	RSA 126-A:5, XIX; §1932(a) of the SSA; 42 U.S.C. 1396u-2
He-W 506.03(d) & (i)[deleted]	§1932(a) of the SSA; 42 CFR 438.2; 42 U.S.C. 1396u-2
He-W 506.05	§1932(a)(4) of the SSA; §1915(b)1 of the SSA; §1915(b)(4) of the SSA; 42 CFR 438.56 and .226
He-W 506.06	§1932(a)(4) of the SSA; 42 CFR 438.52